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106TH CONGRESS
1ST SESSION

H. R. 2824

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 9, 1999

Mr. COBURN (for himself, Mr. SHADEGG, Mr. COOKSEY, Mr. HILLEARY, Mr. VITTER, Mrs. EMERSON, Mr. GILLMOR, Mr. REGULA, Mrs. CUBIN, Mr. GRAHAM, Mr. CUNNINGHAM, and Mr. WELDON of Florida) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of sic provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title I of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Quality and Choice Act of 1999''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed

with input from a range of appropriate practicing physicians, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for an evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by appropriate physician specialists who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits. This subparagraph shall not preclude any capitation arrangements between plans and providers.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to

an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary or appropriate.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—

(A) IN GENERAL.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a de-

termination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the case, and in no event later than the deadline specified in subparagraph (B)

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for prior authorization, and all appropriate information shall be provided at the time of the request.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a utilization review program—

(I) receives a request for a prior authorization,

(II) determines that additional information is necessary to complete the review and make the determination on the request,

(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

(IV) requires the requester to submit specified information not later than 2 business days after notification,

the deadline specified in this subparagraph is 14 days after the date the program receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the prior authorization. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in section 102(c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of the request for prior authorization.

(2) ONGOING CARE.—

(A) CONCURRENT REVIEW.—

(i) IN GENERAL.—Subject to subparagraph (B), in the case of a concurrent re-

view of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider as soon as possible in accordance with the medical exigencies of the case, with sufficient time prior to the termination or reduction to allow for an appeal under section 102(c)(1)(A) to be completed before the termination or reduction takes effect.

(ii) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(B) EXCEPTION.—Subparagraph (A) shall not be interpreted as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination, but in no case later than 60 days after the date of receipt of the claim for benefits.

(4) FAILURE TO MEET DEADLINE.—In a case in which a group health plan or health insurance issuer fails to make a determination on a claim for benefit under paragraph (1), (2)(A), or (3) by the applicable deadline established under the respective paragraph, the failure shall be treated under this subtitle as a denial of the claim as of the date of the deadline.

(5) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, POST-STABILIZATION CARE, AND EMERGENCY AMBULANCE SERVICES.—For waiver of prior authorization re-

quirements in certain cases involving emergency services, maintenance care and post-stabilization care, and emergency ambulance services, see subsections (a)(1), (b), and (c)(1) of section 113, respectively.

(e) NOTICE OF DENIALS OF CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—Notice of a denial of claims for benefits under a utilization review program shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(A) the reasons for the denial (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 102; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such denial.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the denial in order to make a decision on such an appeal.

(f) CLAIM FOR BENEFITS AND DENIAL OF CLAIM FOR BENEFITS DEFINED.—For purposes of this subtitle:

(1) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(2) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, means a denial, or a failure to act on a timely basis upon, in whole or in part, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

SEC. 102. INTERNAL APPEALS PROCEDURES.

(a) RIGHT OF REVIEW.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage—

(A) shall provide adequate notice in writing to any participant or beneficiary under such plan, or enrollee under such coverage, whose claim for benefits under the plan or coverage has been denied (within the meaning of section

101(f)(2)), setting forth the specific reasons for such denial of claim for benefits and rights to any further review or appeal, written in layman's terms to be understood by the participant, beneficiary, or enrollee; and

(B) shall afford such a participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if the individual is medically unable to provide such consent) who is dissatisfied with such a denial of claim for benefits a reasonable opportunity of not less than 180 days to request and obtain a full and fair review by a named fiduciary (with respect to such plan) or named appropriate individual (with respect to such coverage) of the decision denying the claim.

(2) TREATMENT OF ORAL REQUESTS.—The request for review under paragraph (1)(B) may be made orally, but, in the case of an oral request, shall be followed by a request in writing.

(b) INTERNAL REVIEW PROCESS.—

(1) CONDUCT OF REVIEW.—

(A) IN GENERAL.—A review of a denial of claim under this section shall be made by an individual (who shall be a physician in a case involving medical judgment) who has been selected by the plan or issuer and who did not make the initial denial in the internally appealable decision, except that in the case of limited scope coverage (as defined in subparagraph (B)) an appropriate specialist shall review the decision.

(B) LIMITED SCOPE COVERAGE DEFINED.—For purposes of subparagraph (A), the term ''limited scope coverage'' means a group health plan or health insurance coverage the only benefits under which are for benefits described in section 2791(c)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–91(c)(2)).

(2) TIME LIMITS FOR INTERNAL REVIEWS.—

(A) IN GENERAL.—Having received such a request for review of a denial of claim, the plan or issuer shall, in accordance with the medical exigencies of the case but not later than the deadline specified in subparagraph (B), complete the review on the denial and transmit to the participant, beneficiary, enrollee, or other

person involved a decision that affirms, reverses, or modifies the denial. If the decision does not reverse the denial, the plan or issuer shall transmit, in printed form, a notice that sets forth the grounds for such decision and that includes a description of rights to any further appeal. Such decision shall be treated as the final decision of the plan. Failure to issue such a decision by such deadline shall be treated as a final decision affirming the denial of claim.

(B) DEADLINE.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), the deadline specified in this subparagraph is 14 days after the date of receipt of the request for internal review, and all information shall be provided at the time of the request.

(ii) EXTENSION PERMITTED WHERE NOTICE OF ADDITIONAL INFORMATION REQUIRED.—If a group health plan or health insurance issuer—

(I) receives a request for internal review,

(II) determines that additional information is necessary to complete the review and make the determination on the request,

(III) notifies the requester, not later than 5 business days after the date of receiving the request, of the need for such specified additional information, and

(IV) requires the requester to submit specified information not later than 48 hours after notification,

the deadline specified in this subparagraph is 14 days after the date the plan or issuer receives the specified additional information, but in no case later than 28 days after the date of receipt of the request for the internal review. This clause shall not apply if the deadline is specified in clause (iii).

(iii) EXPEDITED CASES.—In the case of a situation described in subsection (c)(1)(A), the deadline specified in this subparagraph is 48 hours after the time of the request for review.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of requests for review under subsection (b) in situations—

(A) in which, as determined by the plan or issuer or as certified in writing by a treating physician, the application of the normal time-frame for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function; or

(B) described in section 101(d)(2) (relating to requests for continuation of ongoing care which would otherwise be reduced or terminated).

(2) PROCESS.—Under such procedures—

(A) the request for expedited review may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the review;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the re-

quester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the review in the case of any of the situations described in subparagraph (A) or (B) of paragraph (1).

(3) DEADLINE FOR DECISION.—The decision on the expedited review must be made and communicated to the parties as soon as possible in accordance with the medical exigencies of the case, and in no event later than 48 hours after the time of receipt of the request for expedited review, except that in a case described in paragraph (1)(B), the decision must be made before the end of the approved period of care.

(d) WAIVER OF PROCESS.—A plan or issuer may waive its rights for an internal review under subsection (b). In such case the participant, beneficiary, or enrollee involved (and any designee or provider involved) shall be relieved of any obligation to complete the review involved and may, at the option of such participant, beneficiary, enrollee, designee, or provider, proceed directly to seek further appeal through any applicable external appeals process.

SEC. 103. EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2), for which a timely appeal is made either by the plan or issuer or by the participant, beneficiary, or enrollee (and any provider or other person acting on behalf of such an individual with the individual's consent or without such consent if such an individual is medically unable to provide such consent).

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term ''externally appealable decision'' means a denial of claim for benefits (as defined in section 101(f)(2)), if—

(i) the item or service involved is a covered benefit,

(ii) the amount involved exceeds $100, and

(iii) the requirements of subparagraph (B) are met with respect to such denial.

Such term also includes a failure to meet an applicable deadline for internal review under section 102 or such standards as are established pursuant to section 118.

(B) REQUIREMENTS.—For purposes of subparagraph (A)(iii), the requirements of this subparagraph are met with respect to a denial of a claim for benefits if—

(i) the denial is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or

(ii) in such denial, the decision as to whether a benefit is covered involves a medical judgment.

(C) EXCLUSIONS.—Such term does not include—

(i) specific exclusions or express limitations on the amount, duration, or scope of coverage; or

(ii) a decision regarding eligibility for any benefits.

(3) EXHAUSTION OF INTERNAL REVIEW PROCESS.—Except as provided under section 102(d), a plan or issuer may condition the use of an external

appeal process in the case of an externally appealable decision upon a final decision in an internal review under section 102, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(4) FILING FEE REQUIREMENT.—

(A) IN GENERAL.—A plan or issuer may condition the use of an external appeal process upon payment in advance to the plan or issuer of a $25 filing fee.

(B) REFUNDING FEE IN CASE OF SUCCESSFUL APPEALS.—The plan or issuer shall refund payment of the filing fee under this paragraph if the recommendation of the external appeal entity is to reverse the denial of a claim for benefits which is the subject of the appeal.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) USE OF QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) IN GENERAL.—Except as provided in subparagraph (D), the external appeal process under this section of a plan or issuer shall be conducted between the plan or issuer and one

or more qualified external appeal entities (as defined in subsection (c)).

(B) LIMITATION ON PLAN OR ISSUER SELECTION.—The applicable authority shall implement procedures—

(i) to assure that the selection process among qualified external appeal entities will not create any incentives for external appeal entities to make a decision in a biased manner, and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

(C) OTHER TERMS AND CONDITIONS.—The terms and conditions of this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external appeal activities. All costs of the process (except those incurred by the participant, beneficiary, enrollee, or treating professional in support of the appeal) shall be paid by the plan or issuer, and not by the participant, beneficiary, or enrollee. The previous sentence shall not be construed as applying to

the imposition of a filing fee under subsection (a)(4).

(D) STATE AUTHORITY WITH RESPECT TO QUALIFIED EXTERNAL APPEAL ENTITY FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(2) ELEMENTS OF PROCESS.—An external appeal process shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR AND DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination described in subparagraph (B) based on evidence described in subparagraphs (C) and (D). However, nothing in this paragraph shall be construed as providing for coverage of items and services for which benefits are not covered under the plan or coverage.

(B) STANDARD OF REVIEW.—An external appeal entity shall determine whether the plan's

or issuer's decision is appropriate for the medical condition of the patient involved (as determined by the entity) taking into account as of the time of the entity's determination the patient's medical condition and any relevant and reliable evidence the entity obtains under subparagraphs (C) and (D). If the entity determines the decision is appropriate for such condition, the entity shall affirm the decision and to the extent that the entity determines the decision is not appropriate for such condition, the entity shall reverse the decision. Nothing in this subparagraph shall be construed as providing for coverage of items or services not provided or covered by the plan.

(C) REQUIRED CONSIDERATION OF CERTAIN MATTERS.—In making such determination, the external appeal entity shall consider, but not be bound by—

(i) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms;

(ii) the decision made by the plan or issuer upon internal review under section 102 and any guidelines or standards used by the plan or issuer in reaching such decision; and

(iii) the opinion of the individual's treating physician or health care professional.

The entity also shall consider any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed.

(D) ADDITIONAL EVIDENCE.—Such entity may also take into consideration but not be limited to the following evidence (to the extent available):

(i) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(ii) The results of professional consensus conferences.

(iii) Practice and treatment policies.

(iv) Community standard of care and generally accepted principles of professional medical practice.

(v) To the extent that the entity determines it to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal.

(vi) To the extent that the entity determines it to be free of any conflict of interest, the results of peer reviews conducted by the plan or issuer involved.

(E) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine—

(i) whether a denial of claim for benefits is an externally appealable decision (within the meaning of subsection (a)(2));

(ii) whether an externally appealable decision involves an expedited appeal;

(iii) for purposes of initiating an external review, whether the internal review process has been completed; and

(iv) whether the denial of claims is a covered benefit.

(F) OPPORTUNITY TO SUBMIT EVIDENCE.—Each party to an externally appealable decision may submit evidence related to the issues in dispute.

(G) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to the external appeal entity to information and to provisions of the plan or health insurance coverage relating to the matter of the externally appealable decision, as determined by the entity.

(H) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 days after the date (or, in the case of an expedited appeal, 48 hours after the time) of requesting an external appeal of the decision;

(iii) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(iv) inform the participant, beneficiary, or enrollee of the individual's rights (including any limitation on such rights) to seek binding arbitration or further review by the courts (or other process) of the external appeal determination.

(I) COMPLIANCE WITH DETERMINATION.—If the external appeal entity determines that a denial of a claim for benefits was not reasonable and reverses the denial, the plan or issuer—

(i) shall (upon the receipt of the determination) authorize benefits in accordance with such determination;

(ii) shall take such actions as may be necessary to provide benefits (including items or services) in a timely manner consistent with such determination; and

(iii) shall submit information to the entity documenting compliance with the

entity's determination and this subparagraph.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity that is certified under paragraph (2) as meeting the following requirements:

(A) The entity meets the independence requirements of paragraph (3).

(B) The entity conducts external appeal activities through at least three clinical peers who are practicing physicians.

(C) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (b)(2)(G).

(2) INITIAL CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1)—

(I) by the Secretary of Labor;

(II) under a process recognized or approved by the Secretary of Labor; or

(III) to the extent provided in subparagraph (C)(i), by a qualified private standard-setting organization (certified under such subparagraph), if elected by the entity; or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements—

(I) by the applicable State authority (or under a process recognized or approved by such authority); or

(II) if the State has not established a certification and recertification process for such entities, by the

Secretary of Health and Human Services, under a process recognized or approved by such Secretary, or to the extent provided in subparagraph (C)(ii), by a qualified private standard-setting organization (certified under such subparagraph), if elected by the entity.

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a review of—

(i) the number of cases reviewed;

(ii) a summary of the disposition of those cases;

(iii) the length of time in making determinations on those cases;

(iv) updated information of what was required to be submitted as a condition of certification for the entity's performance of external appeal activities; and

(v) information necessary to assure that the entity meets the independence requirements (described in paragraph (3))

with respect to plans and issuers for which it conducts external review activities.

(C) CERTIFICATION OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—

(i) FOR EXTERNAL REVIEWS UNDER GROUP HEALTH PLANS.—For purposes of subparagraph (A)(i)(III), the Secretary of Labor may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which provide for certification of external appeal entities. Such an organization shall only be certified if the organization does not certify an external appeal entity unless it meets standards at least as stringent as the standards required for certification of such an entity by such Secretary under subparagraph (A)(i)(I).

(ii) FOR EXTERNAL REVIEWS OF HEALTH INSURANCE ISSUERS.—For purposes of subparagraph (A)(ii)(II), the Secretary of Health and Human Services may provide for a process for certification (and periodic recertification) of qualified private standard-setting organizations which pro-

vide for certification of external appeal entities. Such an organization shall only be certified if the organization does not certify an external appeal entity unless it meets standards as least as stringent as the standards required for certification of such an entity by such Secretary under subparagraph (A)(ii)(II).

(D) CONSTRUCTION.—Nothing in subparagraph (A)(i) shall be construed as permitting the Secretary of Labor to delegate certification authority under subclause (I) of such subparagraph to any person outside the Department of Labor.

(3) INDEPENDENCE REQUIREMENTS.—

(A) IN GENERAL.—A clinical peer or other entity meets the independence requirements of this paragraph if—

(i) the peer or entity is not affiliated with any related party;

(ii) any compensation received by such peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(iii) the plan and the issuer (if any) have no recourse against the peer or entity in connection with the external review; and

(iv) the peer or entity does not otherwise have a conflict of interest with a related party.

(B) RELATED PARTY.—For purposes of this paragraph, the term ''related party'' means—

(i) with respect to—

(I) a group health plan or health insurance coverage offered in connection with such a plan, the plan or the health insurance issuer offering such coverage, or

(II) individual health insurance coverage, the health insurance issuer offering such coverage,

or any plan sponsor, fiduciary, officer, director, or management employee of such plan or issuer;

(ii) the health care professional that provided the health care involved in the coverage decision;

(iii) the institution at which the health care involved in the coverage decision is provided; or

(iv) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision.

(C) AFFILIATED.—For purposes of this paragraph, the term ''affiliated'' means, in connection with any peer or entity, having a familial, financial, or fidicuary relationship with such peer or entity.

(4) LIMITATION ON LIABILITY OF REVIEWERS.—No qualified external appeal entity having a contract with a plan or issuer under this part and no person who is employed by any such entity or who furnishes professional services to such entity, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if due care was exercised in the performance of such duty, function, or activity and there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(d) EXTERNAL APPEAL DETERMINATION BINDING ON PLAN.—

(1) IN GENERAL.—The determination by an external appeal entity under this section shall be binding on the plan (and issuer, if any) involved in the determination.

(2) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as removing any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law, including the right to file judicial actions to enforce rights.

(e) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL APPEAL ENTITY.—

(1) MONETARY PENALTIES.—In any case in which the determination of an external appeal entity is not followed in a timely fashion by a group health plan, or by a health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to $1,000 a day from the date on which the determination was transmitted to the plan

or issuer by the external appeal entity until the date the refusal to provide the benefit is corrected.

(2) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in paragraph (1) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such paragraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity in violation of such terms of the plan, coverage, or this subtitle, or has failed to take an action for which such person is responsible under the plan, coverage, or this title and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(A) to cease and desist from the alleged action or failure to act; and

(B) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(f) PROTECTION OF LEGAL RIGHTS.—Nothing in this subtitle shall be construed as removing or limiting any

legal rights of participants, beneficiaries, enrollees, and others under State or Federal law (including section 502 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

SEC. 104. ESTABLISHMENT OF A GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent or without such consent if the individual is medically unable to provide such consent, regarding any aspect of the plan's or issuer's services.

(2) GRIEVANCE DEFINED.—In this section, the term ''grievance'' means any question, complaint, or concern brought by a participant, beneficiary or enrollee that is not a claim for benefits.

(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants, beneficiaries, or enrollees:

(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

(2) A system to record and document, over a period of at least 3 previous years beginning two months after the date of the enactment of this Act, all grievances and appeals made and their status.

(3) A process providing processing and resolution of grievances within 60 days.

(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

Grievances are not subject to appeal under the previous provisions of this subtitle.

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If a health insurance issuer offers to enrollees health insurance coverage in connection with a group health plan which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network

of health care professionals and providers who have entered into a contract with the issuer to provide such services, the issuer shall also offer to such enrollees (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage which provides for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless enrollees are offered such non-network coverage through another health insurance issuer.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee unless it is paid by the health plan sponsor through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee may change to the offering provided under this section only during a time period determined by the health insurance issuer. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance cov-

erage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—A group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means—

(i) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act; and

(ii) a medical condition manifesting itself in a neonate by acute symptoms of sufficient severity (including severe pain) such that a prudent health care professional could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) with respect to an emergency medical condition described in subparagraph (A)(i)—

(I) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(II) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient; or

(ii) with respect to an emergency medical condition described in subparagraph (A)(ii), medical treatment for such condition rendered by a health care provider in a hospital to a neonate, including available hospital ancillary services in response to an urgent request of a health care profes-

sional and to the extent necessary to stabilize the neonate.

(C) STABILIZE.—The term ''to stabilize'' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—If benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, with respect to maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) (and shall otherwise comply with such guidelines).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2))) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of

bodily function, or serious dysfunction of any bodily organ or part.

SEC. 114. ACCESS TO SPECIALTY CARE.

(a) SPECIALTY CARE FOR COVERED SERVICES.—

(1) IN GENERAL.—If—

(A) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(B) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist or the individual requires physician pathology services, and

(C) benefits for such treatment or services are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible (consistent with standards developed under section 118) to provide the treatment for such condition or disease or to provide such services.

(2) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition or services, a health care practitioner, facility, or center or physician pathologist

that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise and in the case of a pregnant woman, appropriate obstetrical expertise) to provide high quality care in treating the condition or to provide physician pathology services.

(3) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under paragraph (1) with respect to treatment be—

(A) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care

provided, as well as all necessary medical information.

(4) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under paragraph (1) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have a specialist that is available and accessible to treat the individual's condition or provide physician pathology services and that is a participating provider with respect to such treatment or services.

(5) REFERRALS TO NONPARTICIPATING PROVIDERS.—In a case in which a referral of an individual to a nonparticipating specialist is required under paragraph (1), the group health plan or health insurance issuer shall provide the individual the option of at least three nonparticipating specialists.

(6) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to paragraph (1), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the indi-

vidual would otherwise pay for services received by such a specialist that is a participating provider.

(b) SPECIALISTS AS GATEKEEPER FOR TREATMENT OF ONGOING SPECIAL CONDITIONS.—

(1) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in paragraph (3)) may request and receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's care with respect to the condition. Under such procedures if such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(2) TREATMENT FOR RELATED REFERRALS.—Such specialists shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment (referred to in subsection

(a)(3)(A)) with respect to the ongoing special condition.

(3) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(A) is life-threatening, degenerative, or disabling, and

(B) requires specialized medical care over a prolonged period of time.

(4) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

(5) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition from having the individual's primary care physician assume the responsibilities for providing and coordinating care described in paragraph (1).

(c) STANDING REFERRALS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a proce-

dure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist if the individual so desires.

(2) TERMS OF REFERRAL.—The provisions of paragraphs (3) through (5) of subsection (a) apply with respect to referrals under paragraph (1) of this subsection in the same manner as they apply to referrals under subsection (a)(1).

SEC. 115. ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.

(a) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care health care professional, the plan or issuer—

(1) may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of routine gyneco-

logical care (including preventive women's health examinations) and pregnancy-related services provided by a participating physician (including a family practice physician) who specializes or is trained and experienced in obstetrics and gynecology to the extent such care is otherwise covered, and

(2) shall treat the ordering of other obstetrical or gynecological care by such a participating physician as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms of the plan with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrician or gynecologist notify the primary care health care professional or the plan of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) PEDIATRIC CARE.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for an

enrollee to designate a participating primary care provider for a child of such enrollee, the plan or issuer shall permit the enrollee to designate a physician (including a family practice physician) who specializes or is trained and experienced in pediatrics as the child's primary care provider.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms of the plan with respect to coverage of pediatric care.

SEC. 117. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)(B)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing treatment from the provider for an ongoing special condition (as defined in paragraph (3)(A)) at the time of such termination, the plan or issuer shall—

(A) notify the individual on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section; and

(B) subject to subsection (c), permit the individual to elect to continue to be covered with respect treatment by the provider of such condition during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) DEFINITIONS.—For purposes of this section:

(A) ONGOING SPECIAL CONDITION.—The term ''ongoing special condition'' has the meaning given such term in section 114(b)(3), and also includes pregnancy.

(B) TERMINATION.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract by the plan or issuer for failure to meet applicable quality standards or for fraud.

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend up to 90 days (as determined by the treating health care professional) after the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) SCHEDULED SURGERY AND ORGAN TRANSPLANTATION.—If surgery or organ transplantation was scheduled for an individual before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such surgery or transplantation, the transitional period under this sub-

section with respect to the surgery or transplantation shall extend beyond the period under paragraph (1) and until the date of discharge of the individual after completion of the surgery or transplantation.

(3) PREGNANCY.—If—

(A) a participant, beneficiary, or enrollee was determined to be pregnant at the time of a provider's termination of participation, and

(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

(4) TERMINAL ILLNESS.—If—

(A) a participant, beneficiary, or enrollee was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, and

(B) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the individual's life for

care directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the individual notifying the plan of the election of continued coverage and upon the provider agreeing to the following terms and conditions:

(1) The provider agrees to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to

such plan or issuer necessary medical information related to the care provided.

(3) The provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

SEC. 118. NETWORK ADEQUACY.

(a) REQUIREMENT.—A group health plan, and a health insurance issuer providing health insurance coverage, shall meet such standards for network adequacy as are established by law pursuant to this section.

(b) DEVELOPMENT OF STANDARDS.—

(1) ESTABLISHMENT OF PANEL.—There is established a panel to be known as the Health Care Panel to Establish Network Adequacy Standards (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—The Panel shall devise standards for group health plans and health insur-

ance issuers that offer health insurance coverage to ensure that—

(A) participants, beneficiaries, and enrollees have access to a sufficient number, mix, and distribution of health care professionals and providers; and

(B) covered items and services are available and accessible to each participant, beneficiary, and enrollee—

(i) in the service area of the plan or issuer;

(ii) at a variety of sites of service;

(iii) with reasonable promptness (including reasonable hours of operation and after hours services);

(iv) with reasonable proximity to the residences or workplaces of enrollees; and

(v) in a manner that takes into account the diverse needs of enrollees and reasonably assures continuity of care.

(c) MEMBERSHIP.—

(1) SIZE AND COMPOSITION.—The Panel shall be composed of 15 members. The Secretary of Health and Human Services, the Majority Leader of the Senate, and the Speaker of House of Represent-

atives shall each appoint 1 member from representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, and State medical specialty societies.

(2) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(3) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(d) PROCEDURES.—

(1) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(2) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

(3) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(4) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(e) ADMINISTRATION.—

(1) COMPENSATION.—Except as provided in paragraph (1), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(2) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(3) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(4) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(5) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the

Panel on a reimbursable basis such administrative support services as the Panel may request.

(f) REPORT AND ESTABLISHMENT OF STANDARDS.—Not later than 2 years after the first meeting, the Panel shall submit a report to Congress and the Secretary of Health and Human Services detailing the standards devised under subsection (b) and recommendations regarding the implementation of such standards. Such standards shall take effect to the extent provided by Federal law enacted after the date of the submission of such report.

(g) TERMINATION.—The Panel shall terminate on the day after submitting its report to the Secretary of Health and Human Services under subsection (f).

SEC. 119. ACCESS TO EXPERIMENTAL OR INVESTIGATIONAL PRESCRIPTION DRUGS.

No use of a prescription drug or medical device shall be considered experimental or investigational under a group health plan or under health insurance coverage provided by a health insurance issuer if such use is included in the labeling authorized by the U.S. Food and Drug Administration under section 505, 513 or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) or under section 351 of the Public Health Service Act (42 U.S.C. 262), unless such use is demonstrated to be unsafe or ineffective.

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), and at least annually thereafter, the information described in subsection (b);

(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information on such significant changes; and

(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsection (b) or (c).

The plan may charge a reasonable fee for provision in printed form of any of the information described

in subsection (b) or (c) more than once during any plan year.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to enrollees, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c) in printed form.

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer shall be provided to a participant, bene-

ficiary, or enrollee free of charge at least once a year and includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) those that are covered benefits (by reference to relevant CPT and DRG codes), limits and conditions on such benefits, and those benefits that are explicitly excluded from coverage (by reference to relevant CPT and DRG codes);

(B) cost sharing, such as deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

(3) ACCESS.—A description of the following:

(A) The number, mix, and distribution of providers under the plan or coverage.

(B) Out-of-network coverage (if any) provided by the plan or coverage.

(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

(D) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(E) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

(G) Any limitations imposed on the selection of qualifying participating health care pro-

viders, including any limitations imposed under section 112(b)(2).

(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances

for acting on grievances and appeals, who is the applicable authority with respect to the plan or issuer.

(8) ACCOUNTABILITY.—A description of the legal recourse options available for participants and beneficiaries under the plan including—

(A) the preemption that applies under section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) to certain actions arising out of the provision of health benefits; and

(B) the extent to which coverage decisions made by the plan are subject to internal review or any external review and the proper time frames under.

(9) QUALITY ASSURANCE.—Any information made public by an accrediting organization in the process of accreditation of the plan or issuer or any additional quality indicators the plan or issuer makes available.

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 101.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

(4) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

(d) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

(c) CONSTRUCTION.—Nothing in this title shall be construed to require the sponsor of a group health plan, or a health insurance issuer offering health insurance cov-

erage in connection with the group health plan, to provide, reimburse for, or provide coverage of, a counseling or referral service if the plan or issuer objects to the provision of such service on moral or religious grounds.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(b) CONSTRUCTION.—Subsection (a) shall not be construed—

(1) as requiring the coverage under a group health plan or health insurance coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

(2) to override any State licensure or scope-of-practice law;

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer; or

(4) as prohibiting a family practice physician with appropriate expertise from providing pediatric or obstetrical or gynecological care.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively,

and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLEAN CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act (42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)), except that for purposes of this section, subparagraph (C) of section 1816(c)(2) of the Social Security Act shall be treated as applying to claims received from a participant, beneficiary, or enrollee as well as claims referred to in such subparagraph.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2971 of the Public Health Service Act shall apply for pur-

poses of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such

provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, a practicing physician or other health care professional who holds a nonrestricted license and who is—

(A) appropriately certified by a nationally recognized, peer reviewed accrediting body in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review or appeal, or

(B) is trained and experienced in managing such condition, procedure, or treatment, and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment recommended or rendered by a physician.

(3) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(4) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974.

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(6) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(7) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(8) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health

care provider that is not a participating health care provider with respect to such items and services.

(9) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(10) PHYSICIAN.—The term ''physician'' means an allopathic or osteopathic physician.

(11) PRACTICING PHYSICIAN.—The term ''practicing physician'' means a physician who is licensed in the State in which the physician furnishes professional services and who provides professional services to individual patients on average at least two full days per week.

(12) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(b) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

SEC. 153. EXCLUSIONS.

(a) NO BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to provide specific benefits under the terms of such plan or coverage, other than those provided under the terms of such plan or coverage.

(b) EXCLUSION FROM ACCESS TO CARE MANAGED CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.—

(1) IN GENERAL.—The provisions of sections 111 through 117 shall not apply to a group health plan or health insurance coverage if the only coverage offered under the plan or coverage is fee-for-service coverage (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE COVERAGE DEFINED.—For purposes of this subsection, the term ''fee-for-service coverage'' means coverage under a group health plan or health insurance coverage that—

(A) reimburses hospitals, health professionals, and other providers on the basis of a

rate determined by the plan or issuer on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing coverage for any services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS; COORDINATION; APPLICATION UNDER DIFFERENT LAWS.

(a) REGULATIONS.—The Secretaries of Health and Human Services, Labor, and the Treasury shall each issue such regulations as may be necessary or appropriate to carry out this title under sections 2707 and 2753 of the Public Health Service Act, under section 714 of the Employee Retirement Income Security Act of 1974, and under section 9813 of the Internal Revenue Code of 1986, respectively. Such Secretaries may promulgate such regulations in the form of interim final rules as may be necessary to carry out this Act in a timely manner.

(b) ASSURING COORDINATION.—Such Secretaries shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this title (and the amendments made by titles II, III, and IV) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy

that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(c) APPLICATION OF SUBTITLE UNDER DIFFERENT LAWS.—The provisions of this subtitle shall be applied—

(1) by the Secretary of Health and Human Services under (and only under) title XXVII of the Public Health Service Act (and not under Employee Retirement Income Security Act of 1974 or the Internal Revenue Code of 1986);

(2) by the Secretary of Labor under (and only under) part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (and not under the Public Health Service Act or the Internal Revenue Code of 1986); and

(3) by the Secretary of the Treasury under (and only under) chapter 100 of the Internal Revenue Code of 1986 (and not under the Public Health Service Act or the Employee Retirement Income Security Act of 1974).

(d) CONSTRUCTION.—Nothing in this subtitle shall be construed as preventing the Congress from providing for different quality care policies for application under the different titles, parts, and chapters referenced in subsection (c).

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

"SEC. 2707. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Health Care Quality and Choice Act of 1999 (as in effect on the date of the enactment of such Act), and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 (as in effect on the date of the enactment of the Health Care Quality and Choice Act of 1999) with respect to the require-

ments referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2707)'' after ''requirements of such subparts''.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

''SEC. 2753. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Health Care Quality and Choice Act of 1999 (as in effect on the date of the enactment of such Act) with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title

as if such section applied to such issuer and such issuer were a group health plan.''.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 714. PATIENT PROTECTION STANDARDS.

''A group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Health Care Quality and Choice Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C.

1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Health Care Quality and Choice Act of 1999 (as in effect on the date of the enactment of such Act) in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Patient protection standards.''.

SEC. 302. AVAILABILITY OF COURT REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

''(1) IN GENERAL.—In any case in which—

''(A) a person who is a fiduciary of a group health plan, a health insurance issuer of-

fering health insurance coverage in connection with the plan, or an agent of the plan or plan sponsor and who, under the plan, has authority to make final decisions under section 102 of the Health Care Quality and Choice Act of 1999—

''(i) fails to exercise ordinary care in making an incorrect determination in the case of a participant or beneficiary that an item or service is excluded from coverage under the terms of the plan based on the fact that the item or service—

''(I) does not meet the requirements for medical appropriateness or necessity,

''(II) would constitute experimental treatment or technology (as defined under the plan), or

''(III) is not a covered benefit, or

''(ii) fails to exercise ordinary care to ensure that—

''(I) any denial of claim for benefits (within the meaning of section 101(f) of the Health Care Quality and Choice Act of 1999), or

"(II) any decision by the plan on a request, made by a participant or beneficiary under section 102 or 103 of the Health Care Quality and Choice Act of 1999, for a reversal of an earlier decision of the plan,

is made and issued to the participant or beneficiary (in such form and manner as may be prescribed in regulations of the Secretary) before the end of the applicable period specified in section 101, 102, or 103 of the Health Care Quality and Choice Act of 1999, and

"(B) such failure is the proximate cause of personal injury to, or wrongful death of, the participant or beneficiary,

such person shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (10)).

For purposes of this subsection, the term 'final decision' means, with respect to a group health plan, a final decision of the plan under section 102 of the Health Care Quality and Choice Act of 1999.

''(2) ORDINARY CARE.—For purposes of this subsection, the term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent individual acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

''(3) PERSONAL INJURY.—For purposes of this subsection, the term 'personal injury' means a physical injury and includes a physical injury arising out of a failure to treat a mental illness or disease.

''(4) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

''(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

''(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pur-

suant to a cause of action under paragraph (1).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) commenced against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment), but only if—

''(i) such action is based on the direct participation of the employer or other plan sponsor (or employee of the employer or plan sponsor) in the final decision of the plan with respect to a specific participant or beneficiary on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the decision on the claim resulted in personal injury to, or the wrongful death of, such participant or beneficiary.

''(C) DIRECT PARTICIPATION.—For purposes of this subsection, in determining whether an employer or other plan sponsor (or employee of an employer or other plan sponsor) is engaged in direct participation in the final decision of the plan on a claim, the employer or

plan sponsor (or employee) shall not be construed to be engaged in such direct participation (and to be liable for any damages whatsoever) because of—

''(i) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

''(ii) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

''(iii) any decision to increase or decrease coverage or benefits affecting all plan participants or beneficiaries made in the initial purchase or regular renewal of coverage by the employer or plan sponsor (or employee);

''(iv) any action by an agent of the employer or plan sponsor in making such a final decision on behalf of such employer or plan sponsor;

''(v) any decision by an employer or plan sponsor (or employee) or agent acting on behalf of an employer or plan sponsor either to authorize coverage for, or to intercede or not to intercede as an advocate for or on behalf of, any specific participant or beneficiary (or group of participants or beneficiaries) under the plan; or

''(vi) any other form of decision-making or other conduct performed by the employer or other plan sponsor (or employee) in connection with the plan or coverage involved unless it involves the making of a final decision of the plan consisting of a failure described in clause (i) or (ii) of paragraph (1)(A) as to specific participants or beneficiaries who suffer personal injury or wrongful death as a proximate cause of such decision.

''(5) REQUIRED DEMONSTRATION OF DIRECT PARTICIPATION.—An action against an employer or plan sponsor (or employee thereof) under this subsection shall be immediately dismissed—

''(A) in the absence of an allegation in the complaint of direct participation by the em-

ployer or plan sponsor in the final decision of the plan with respect to a specific participant or beneficiary who suffers personal injury or wrongful death, or

"(B) upon a demonstration to the court that such employer or plan sponsor (or employee) did not directly participate in the final decision of the plan.

"(6) TREATMENT OF THIRD-PARTY PROVIDERS OF NONDISCRETIONARY ADMINISTRATIVE SERVICES.—Paragraph (1) does not authorize any action against any person providing nondiscretionary administrative services to employers or other plan sponsors.

"(7) REQUIREMENT OF EXHAUSTION OF ADMINISTRATIVE REMEDIES.—

"(A) IN GENERAL.—Paragraph (1) applies in the case of any cause of action only if all remedies under section 503 (including remedies under sections 102 and 103 of the Health Care Quality and Choice Act of 1999 made applicable under section 714) with respect to such cause of action have been exhausted.

"(B) EXTERNAL REVIEW REQUIRED.—For purposes of subparagraph (A), administrative

remedies under section 503 shall not be deemed exhausted until available remedies under section 103 of the Health Care Quality and Choice Act of 1999 have been elected and are exhausted.

''(C) CONSIDERATION OF ADMINISTRATIVE DETERMINATIONS.—Any determinations made under section 102 or 103 of the Health Care Quality and Choice Act of 1999 made while an action under this paragraph is pending shall be given due consideration by the court in such action.

''(8) USE OF EXTERNAL APPEAL ENTITY IN ESTABLISHING ABSENCE OF PERSONAL INJURY OR CAUSATION IN LITIGATION.—

''(A) IN GENERAL.—In any action under this subsection by an individual in which damages are sought on the basis of a personal injury to the individual, the defendant may obtain (at its own expense), under procedures similar to procedures applicable under section 103 of the Health Care Quality and Choice Act of 1999, a determination by a qualified external appeal entity (as defined in section 103(c)(1) of the Health Care Quality and Choice Act of 1999) that has not been involved in any stage

of the grievance or appeals process which resulted in such action as to—

"(i) whether or not such a personal injury has been sustained, or

"(ii) whether or not the proximate cause of such injury was the result of the failure of the defendant to exercise ordinary care, as described in paragraph (1)(A).

"(B) EFFECT OF FINDING IN FAVOR OF DEFENDANT.—If the external appeal entity determines that such an injury has not been sustained or was not proximately caused by such a failure, such a finding shall be an affirmative defense, the action shall be dismissed forthwith, and all liability based upon the alleged injury shall be precluded.

"(9) REBUTTABLE PRESUMPTION.—In the case of any action commenced pursuant to paragraph (1), there shall be a rebuttable presumption in favor of the decision of the external appeal entity rendered upon completion of any review elected under section 103 of the Health Care Quality and Choice Act of 1999 and such presumption may be overcome only

upon a showing of clear and convincing evidence to the contrary.

''(10) MAXIMUM NONECONOMIC DAMAGES.—Total liability for noneconomic loss under this subsection in connection with any failure with respect to any participant or beneficiary may not exceed the greater of—

''(A) $250,000, or

''(B) 2 times the amount of economic loss.

''(11) PROHIBITION OF AWARD OF PUNITIVE DAMAGES.—

''(A) GENERAL RULE.—Except as provided in this paragraph, nothing in this subsection shall be construed as authorizing a cause of action for punitive, exemplary, or similar damages.

''(B) EXCEPTION.—Punitive damages are authorized in any case described in paragraph (1)(A)(ii) in which the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with a conscious, flagrant indifference to the rights or safety of others was the proximate cause of the harm that is the subject of the action and that such conduct was contrary to the recommendations of

an external appeal entity issued in any determination (if any) in such case rendered pursuant to section 103 of the Health Care Quality and Choice Act of 1999.

''(C) LIMITATION ON AMOUNT.—

''(i) IN GENERAL.—The amount of punitive damages that may be awarded in an action described in subparagraph (B) may not exceed the greater of—

''(I) 2 times the sum of the amount awarded to the claimant for economic loss; or

''(II) $250,000.

''(ii) SPECIAL RULE.—Notwithstanding clause (i), in any action described in subparagraph (B) against an individual whose net worth does not exceed $500,000 or against an owner of an unincorporated business, or any partnership, corporation, association, unit of local government, or organization which has fewer that 25 employees, the punitive damages shall not exceed the lesser of—

''(I) 2 times the amount awarded to the claimant for economic loss; or

"(II) $250,000.

"(iii) CONTROLLED GROUPS.—

"(I) IN GENERAL.—For the purpose of determining the applicability of clause (ii) to any employer, in determining the number of employees of an employer who is a member of a controlled group, the employees of any person in such group shall be deemed to be employees of the employer.

"(II) CONTROLLED GROUP.—For purposes of subclause (I), the term 'controlled group' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

"(D) EXCEPTION FOR INSUFFICIENT AWARD IN CASES OF EGREGIOUS CONDUCT.—

"(i) DETERMINATION BY COURT.—If the court makes a determination, after considering each of the factors in subparagraph (E), that the application of subparagraph (B) would result in an award of punitive damages that is insufficient to pun-

ish the egregious conduct of the defendant against whom the punitive damages are to be awarded or to deter such conduct in the future, the court shall determine the additional amount of punitive damages (referred to in this subparagraph as the 'additional amount') in excess of the amount determined in accordance with subparagraph (B) to be awarded against the defendant in a separate proceeding in accordance with this subparagraph.

''(ii) REQUIREMENTS FOR AWARDING ADDITIONAL AMOUNT.—If the court awards an additional amount pursuant to this subparagraph, the court shall state its reasons for setting the amount of the additional amount in findings of fact and conclusions of law.

''(E) FACTORS FOR CONSIDERATION IN CASES OF EGREGIOUS CONDUCT.—In any proceeding under subparagraph (D), the matters to be considered by the court shall include (but are not limited to)—

''(i) the extent to which the defendant acted with actual malice;

''(ii) the likelihood that serious harm would arise from the conduct of the defendant;

''(iii) the degree of the awareness of the defendant of that likelihood;

''(iv) the profitability of the misconduct to the defendant;

''(v) the duration of the misconduct and any concurrent or subsequent concealment of the conduct by the defendant;

''(vi) the attitude and conduct of the defendant upon the discovery of the misconduct and whether the misconduct has terminated;

''(vii) the financial condition of the defendant; and

''(viii) the cumulative deterrent effect of other losses, damages, and punishment suffered by the defendant as a result of the misconduct, reducing the amount of punitive damages on the basis of the economic impact and severity of all measures to which the defendant has been or may be subjected, including—

''(I) compensatory and punitive damage awards to similarly situated claimants;

''(II) the adverse economic effect of stigma or loss of reputation;

''(III) civil fines and criminal and administrative penalties; and

''(IV) stop sale, cease and desist, and other remedial or enforcement orders.

''(F) APPLICATION BY COURT.—This paragraph shall be applied by the court and, in the case of a trial by jury, application of this paragraph shall not be disclosed to the jury. Nothing in this paragraph shall authorize the court to enter an additional award of punitive damages in excess of the amount of the jury's initial award of punitive damages.

''(G) LIMITATION ON PUNITIVE DAMAGES.—No person shall be liable for punitive, exemplary, or similar damages in an action under this subsection based on any failure described in paragraph (1) if such failure was in compliance with the recommendations of an external appeal entity issued in a determination

under section 103 of the Health Care Quality and Choice Act of 1999.

''(H) BIFURCATION AT REQUEST OF ANY PARTY.—

''(i) IN GENERAL.—At the request of any party the trier of fact in any action that is subject to this paragraph shall consider in a separate proceeding, held subsequent to the determination of the amount of compensatory damages, whether punitive damages are to be awarded for the harm that is the subject of the action and the amount of the award.

''(ii) INADMISSIBILITY OF EVIDENCE RELATIVE ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PROCEEDING CONCERNING COMPENSATORY DAMAGES.—If any party requests a separate proceeding under clause (i), in a proceeding to determine whether the claimant may be awarded compensatory damages, any evidence, argument, or contention that is relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible.

''(12) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after the later of—

''(A) 1 year after (i) the date of the last action which constituted a part of the failure, or (ii) in the case of an omission, the latest date on which the fiduciary could have cured the failure, or

''(B) 1 year after the earliest date on which the plaintiff first knew, or reasonably should have known, of the bodily injury resulting from the failure.

''(13) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by a fiduciary which consists of full compliance with the reversal under section 103 of the Health Care Quality and Choice Act of 1999 of a denial of claim for benefits (within the meaning of section 101(f) of such Act).

''(14) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action for the failure to provide an item or service which is not covered under the group health plan involved.

''(15) PROTECTION OF MEDICAL MALPRACTICE AND SIMILAR ACTIONS UNDER STATE LAW.—This subsection shall not be construed to preclude any action under State law (as defined in section 514(c)(1)) with respect to the duty (if any) under such State law imposed on any person to exercise a specified standard of care when making a health care treatment decision where medical services are provided by such person and the decision affects the quality of care or treatment provided or received.

''(16) REFERENCES TO THE HEALTH CARE QUALITY AND CHOICE ACT OF 1999.—Any reference in this subsection to any provision of the Health Care Quality and Choice Act of 1999 shall be deemed a reference to such provision as in effect on the date of the enactment of such Act.''.

(b) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of such Act (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after the date of the enactment of this Act.

SEC. 303. AVAILABILITY OF BINDING ARBITRATION.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (as amended by the preceding provisions of this Act) is amended further—

(1) in subsection (a), by inserting ''IN GENERAL.—'' after ''(a)'';

(2) in subsection (b), by striking ''(b) In the case'' and inserting the following:

''(b) GROUP HEALTH PLANS.—

''(1) IN GENERAL.—In the case''; and

(3) by adding at the end of subsection (b) the following:

''(2) BINDING ARBITRATION PERMITTED AS ALTERNATIVE MEANS OF DISPUTE RESOLUTION.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements of the preceding provisions of this section relating to review of any adverse coverage decision rendered by or under the plan, if—

''(i) in lieu of the procedures otherwise provided under the plan in accordance with such provisions and in lieu of any subsequent review of the matter by a court under section 502—

"(I) the aggrieved participant or beneficiary elects in the request for the review a procedure by which the dispute is resolved by binding arbitration which is available under the plan with respect to similarly situated participants and beneficiaries and which meets the requirements of subparagraph (B); or

"(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of binding arbitration which meets the requirements of subparagraph (B); and

"(ii) the additional requirements of subparagraph (B) are met.

"(B) ADDITIONAL REQUIREMENTS.—The Secretary shall prescribe by regulation requirements for arbitration procedures under this paragraph, including at least the following requirements:

''(i) ARBITRATION PANEL.—The arbitration shall be conducted by an arbitration panel meeting the requirements of subparagraph (C).

''(ii) FAIR PROCESS; DE NOVO DETERMINATION.—The procedure shall provide for a fair, de novo determination.

''(iii) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to the arbitration procedure—

''(I) may submit and review evidence related to the issues in dispute;

''(II) may use the assistance or representation of one or more individuals (any of whom may be an attorney); and

''(III) may make an oral presentation.

''(iv) PROVISION OF INFORMATION.—The plan shall provide timely access to all its records relating to the matters under arbitration and to all provisions of the plan relating to such matters.

''(v) TIMELY DECISIONS.—A determination by the arbitration panel on the decision shall—

''(I) be made in writing;

''(II) be binding on the parties; and

''(III) be made in accordance with the medical exigencies of the case involved.

''(C) ARBITRATION PANEL.—

''(i) IN GENERAL.—Arbitrations commenced pursuant to this paragraph shall be conducted by a panel of arbitrators selected by the parties made up of 3 individuals, including at least one practicing physician and one practicing attorney.

''(ii) QUALIFICATIONS.—Any individual who is a member of an arbitration panel shall meet the following requirements:

''(I) There is no real or apparent conflict of interest that would impede the individual conducting arbitration independent of the plan and meets the

independence requirements of clause (iii).

''(II) The individual has sufficient medical or legal expertise to conduct the arbitration for the plan on a timely basis.

''(III) The individual has appropriate credentials and has attained recognized expertise in the applicable medical or legal field.

''(IV) The individual was not involved in the initial adverse coverage decision or any other review thereof.

''(iii) INDEPENDENCE REQUIREMENTS.—An individual described in clause (ii) meets the independence requirements of this clause if—

''(I) the individual is not affiliated with any related party,

''(II) any compensation received by such individual in connection with the binding arbitration procedure is reasonable and not contingent on any decision rendered by the individual,

''(III) under the terms of the plan, the plan has no recourse against the individual or entity in connection with the binding arbitration procedure, and

''(IV) the individual does not otherwise have a conflict of interest with a related party as determined under such regulations as the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (iii), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

''(V) any other party determined under such regulations as the Secretary may prescribe to have a substantial interest in the coverage decision .

''(iv) AFFILIATED.—For purposes of clause (iii), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(D) DECISIONS.—

''(i) IN GENERAL.—Decisions rendered by the arbitration panel shall be binding on all parties to the arbitration and shall be enforcible under section 502 as if the terms of the decision were the terms of the plan, except that the court may vacate any award made pursuant to the arbitration for any cause described in paragraph (1), (2), (3), (4), or (5) of section 10(a) of title 9, United States Code.

''(ii) ALLOWABLE REMEDIES.—The remedies which may be implemented by the arbitration panel shall consist of those remedies which would be available in an action timely commenced by a participant or beneficiary under section 502 after exhaustion of administrative remedies.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to adverse coverage decisions initially rendered by group health plans on or after the date of the enactment of this Act.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to Health Care Quality and Choice Act.''; and

(2) by inserting after section 9812 the following:

"SEC. 9813. STANDARD RELATING TO HEALTH CARE QUALITY AND CHOICE ACT.

"A group health plan shall comply with the requirements of title I of the Health Care Quality and Choice Act of 1999 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.".

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2000 (in this section referred to as the "general effective date") and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representa-

tives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall

ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which both Secretaries have responsibility under the provisions of this Act (and the amendments made thereby) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE VI—OTHER PROVISIONS

SEC. 601. HEALTH CARE PAPERWORK SIMPLIFICATION.

(a) ESTABLISHMENT OF PANEL.—

(1) ESTABLISHMENT.—There is established a panel to be known as the Health Care Panel to Devise a Uniform Explanation of Benefits (in this section referred to as the ''Panel'').

(2) DUTIES OF PANEL.—

(A) IN GENERAL.—The Panel shall devise a single form for use by third-party health care payers for the remittance of claims to providers.

(B) DEFINITION.—For purposes of this section, the term ''third-party health care payer'' means any entity that contractually pays health care bills for an individual.

(3) MEMBERSHIP.—

(A) SIZE AND COMPOSITION.—The Secretary of Health and Human Services, in consultation with the Majority Leader of the Senate and the Speaker of the House of Representatives, shall determine the number of members and the composition of the Panel. Such Panel shall include equal numbers of representatives of private insurance organizations, consumer groups, State insurance commissioners, State medical societies, State hospital associations, and State medical specialty societies.

(B) TERMS OF APPOINTMENT.—The members of the Panel shall serve for the life of the Panel.

(C) VACANCIES.—A vacancy in the Panel shall not affect the power of the remaining members to execute the duties of the Panel, but any such vacancy shall be filled in the same manner in which the original appointment was made.

(4) PROCEDURES.—

(A) MEETINGS.—The Panel shall meet at the call of a majority of its members.

(B) FIRST MEETING.—The Panel shall convene not later than 60 days after the date of the enactment of the Health Care Quality and Choice Act of 1999.

(C) QUORUM.—A quorum shall consist of a majority of the members of the Panel.

(D) HEARINGS.—For the purpose of carrying out its duties, the Panel may hold such hearings and undertake such other activities as the Panel determines to be necessary to carry out its duties.

(5) ADMINISTRATION.—

(A) COMPENSATION.—Except as provided in subparagraph (B), members of the Panel shall receive no additional pay, allowances, or benefits by reason of their service on the Panel.

(B) TRAVEL EXPENSES AND PER DIEM.—Each member of the Panel who is not an officer or employee of the Federal Government shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(C) CONTRACT AUTHORITY.—The Panel may contract with and compensate government and private agencies or persons for items and services, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(D) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(E) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Panel, the Secretary of Health and Human Services shall provide to the Panel on a reimbursable basis such administrative support services as the Panel may request.

(6) SUBMISSION OF FORM.—Not later than 2 years after the first meeting, the Panel shall submit a form to the Secretary of Health and Human Services for use by third-party health care payers.

(7) TERMINATION.—The Panel shall terminate on the day after submitting its the form under paragraph (6).

(b) REQUIREMENT FOR USE OF FORM BY THIRD-PARTY CARE PAYERS.—A third-party health care payer shall be required to use the form devised under subsection (a) for plan years beginning on or after 5 years following the date of the enactment of this Act.

SEC. 602. PROTECTION FOR CERTAIN INFORMATION.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discover, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

(c) DEFINITIONS.—For purposes of this section:

(1) ACCREDITING BODY.—The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) HEALTH CARE RESPONSE INFORMATION.—The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care

provider in response to a serious, adverse, patient related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for the purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

(B) a Federal, State, or employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer or employee of a person described in subparagraph (A) or (B).

(4) STATE.—The term ''State'' includes a State, the District of Columbia, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(d) EFFECTIVE DATE.—The provisions of this section are effective on the date of the enactment of this Act.

SEC. 603. MEDICARE COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) FINDING.—The Congress finds that implementing competitive pricing in the medicare program under title XVIII of the Social Security Act is an important goal.

(b) PROHIBITION ON IMPLEMENTATION OF PROJECT IN CERTAIN AREAS.—Notwithstanding subsection (b) of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project (operated by the Secretary of Health and Human Services pursuant to such section) in Kansas City, Missouri or Kansas City, Kansas, or in any area in Arizona.

(c) MORATORIUM ON IMPLEMENTATION OF PROJECT IN ANY AREA UNTIL JANUARY, 1, 2001.—Notwithstanding any provision of section 4011 of the Balanced Budget Act of 1997 (Public Law 105–33)), the Secretary of Health and Human Services may not implement the Medicare Competitive Pricing Demonstration Project in any area before January 1, 2001.

(d) STUDY AND REPORT TO CONGRESS.—

(1) STUDY.—The Secretary of Health and Human Services, in conjunction with the Competitive Pricing Advisory Committee, shall conduct a study on the different approaches of implementing the Medicare Competitive Pricing Demonstration Project on a voluntary basis.

(2) REPORT.—Not later than June 30, 2000, the Secretary of Health and Human Services shall submit a report to Congress which shall contain a detailed description of the study conducted under paragraph (1), together with the recommendations of the Secretary and the Competitive Pricing Advisory Committee regarding the implementation of the Medicare Competitive Pricing Demonstration Project.

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